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Journal of the Alumni Association of the
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STORAGE

ALBANY MEDICAL ANNALS

Journal of the Alumni Association of the Albany Medical College

EDITED BY
J. MONTGOMERY MOSHER, M. D.

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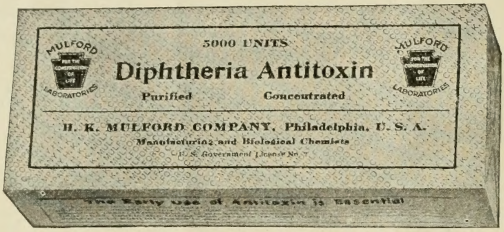

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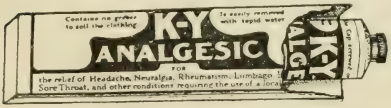

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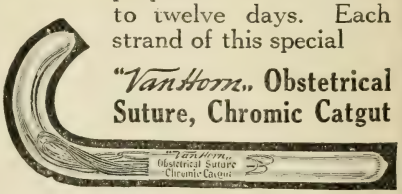

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VOL. XL SEPTEMBER, 1919 No. 9

ALBANY MEDICAL ANNALS

Original Communications

CONFERENCE ON GENERAL LAWS RELATING TO DUTIES AND POWERS OF HEALTH OFFICERS AND HEALTH BOARDS.

Lecture delivered in the Post-Graduate Course in Infectious Diseases and Public Health for Physicians and Health Officers at the Albany Medical College, Wednesday, May 28, 1919.

BY JOSEPH A. WARREN,
Legal Advisor, New York State Department of Health.

During the discussion of the paper assigned to me I shall confine myself strictly to the subject as stated. This is headed "Conference on General Laws Relating to Duties and Powers of Health Officers and Health Boards." I shall therefore not attempt to go into any extended discussion of details as to procedure or other such matters, but will endeavor to review the fundamental principles, as expressed chiefly in the Public Health Law, which control the powers and duties of health officers. This eliminates any discussion of the State Sanitary Code or of local ordinances. Should I go beyond these limits, we would wander far afield and not be able in the space of time allowed adequately to cover the subject. Moreover, since all of the details as to procedure are based upon the fundamental principles it is much more important that these principles be thoroughly understood.

I shall endeavor to divide my subject into five different heads, as follows:

1. General powers and duties of health officers.
2. Powers and duties of health officers in case of an epidemic.

3. Powers and duties of health officers as to nuisances.

4. Powers and duties of health officers in reference to tuberculosis.

5. Powers and duties of health officers as to venereal disease.

1. *General powers and duties of health officers.*—Section 21-b of the Public Health Law contains an outline of the general powers and duties of health officers. It provides that (1) the health officer must make an annual sanitary survey of his district and maintain continuous sanitary supervision thereof; (2) where no medical examination is made by the Department of Education the officer must make a medical examination of every school child as soon as practical after the opening of each school year; (3) he must make periodically a sanitary inspection of all school buildings and places of public assemblage and report thereon to the persons responsible for the maintenance and management of the same; (4) he must take such steps as possible to educate the public as to the causes, nature and prevention of prevalent diseases and the preservation and improvement of health; (5) he must take such steps as may be necessary to secure prompt and full reports by physicians of communicable diseases and of births and deaths; (6) he must generally enforce within his jurisdiction the provisions of the Public Health Law and the Sanitary Code; and (7) he must attend the annual conference of sanitary officers called by the State Department of Health and all local conferences called by the Sanitary Supervisor of the territory which includes his district.

It will be observed that in the main all of these duties and powers are general in their terms, and it is obvious that in the nature of things this is necessary. It would be unwise in the law to attempt to lay out in advance the exact limits of the powers and duties of health officers. No Legislature is wise enough to be able to foretell the contingencies which may arise and therefore in the ultimate analysis the exact course of action which a health officer must take must be governed largely by his common sense and good judgment.

Section 25 of the Public Health Law deals specifically with the subject of infectious and communicable diseases, and gives coordinate jurisdiction to the local boards of health and health

officers to take all necessary measures to prevent the spread of such diseases. In the succeeding heading I shall discuss the effect of the courts ruling on the broad provisions of this section. For the present it is to be noted that the health officer in the presence of a communicable disease may, subject to the provisions of the Sanitary Code, prohibit and prevent all intercourse and communication with infected places or things and may provide, if necessary, for thorough purification and cleansing of such infected places or things before general intercourse is allowed. The health officer is also required to report immediately to the State Department of Health all cases of communicable disease arising within his district.

By section 21-c of the Law the health officer is empowered to employ such number of public health nurses as is necessary within the limits of his appropriation and by section 21 he is authorized to employ such other persons as are necessary to carry into effect the orders and regulations of the board of health, the provisions of the Pubic Health Law and of the Sanitary Code, and to fix their compensation within the limits of the appropriation made for his use by the local board of health.

Under section 33 it is forbidden that any room or apartment in a tenement or dwelling house used for eating and sleeping purposes shall be used in the manufacture, wholly or partly, of coats, vests, trousers, knee pants, overalls, cloaks, shirts, purses, feathers, artificial flowers or cigars, except by the members of the family living therein, unless a permit has been granted by the local board of health. The health officer has the right to inspect these places and to destroy any infectious or contagious articles found therein; also to take such other steps as may be necessary for the preservation of the public health. It is, of course, fundamental that the health officer has power to enter any place within his district for the purpose of inspection and for ascertaining whether or not the provisions of law in reference to public health are being complied with.

Under section 21-b the written reports of health officers, made in pursuance of their duties, are presumptive evidence of the facts stated in such report and the health officer is not responsible in any action for any statements in such report unless it is proved that he acted in bad faith. This provision, as we shall

see later on in this discussion, is of the utmost importance and it should be constantly kept in mind and used by all local health officers.

2. *Powers and duties of health officers in case of an epidemic.* —Section 25 of the Public Health Law, as has been stated, imposes upon health officers the duty of guarding against the introduction of infectious, contagious or communicable disease by the exercise of proper and vigilant medical inspection and control of all persons and things infected with or exposed to such diseases. It would seem that this wording is sufficiently broad to give either to the board of health or to the health officer practically unlimited authority within reason to take any steps necessary toward the end in view.

Since 1895, however, the powers of a health officer have been greatly restricted by reason of a decision of the Court of Appeals handed down in that year. That court, in the Matter of Smith, 146 New York, 68, held that under the provisions of the then section 14 of the Public Health Law (now substantially reenacted as section 25) a health officer had no power to quarantine or isolate a person whom he had reason to suspect had been exposed to a communicable disease, even in the event of an epidemic, unless such person had actually been exposed to or infected with such disease. The effect of this decision is clear. No health officer could quarantine or isolate any person for a communicable disease and feel entirely safe in so doing. If his diagnosis should turn out to be incorrect and the person was not infected with the disease, or if he should not have the very difficult and technical legal proof required to show that the person had been actually exposed to such disease, then he would lay himself open to an action for false imprisonment with the consequent damages.

While there is no definite evidence to show the result of this, it is only natural that this holding of the Court of Appeals has tended to make health officers too careful in the performance of their duties in the case of an epidemic and, it may be, has given opportunities for the spread of epidemics which would not have occurred had the health officers felt themselves freer.

The writer has always felt that if the Smith case were presented to the Court of Appeals at this time, instead of over

twenty years ago, a different conclusion would be reached and that this opinion is reasonably correct is evidenced by the recent case of Crayton vs. Larabee, 220 New York, 493, decided in 1917. In the Crayton case a local ordinance of the city of Syracuse directed the health officer to order isolation or absolute quarantine of any house or person deemed by the health officer to be necessary in the case of a communicable disease. Under the provisions of this ordinance the health officer of Syracuse quarantined the plaintiff. There was no proof in the case that the plaintiff had ever been infected with or exposed to a communicable disease. Nevertheless, the Court of Appeals upheld the action of the health officer. This decision of the Court of Appeals was based upon the ground that the ordinance of the city of Syracuse authorized the action of the health officer; that this ordinance in turn was authorized by the provisions of the Second Class Cities Law. A reading of the provisions of the Second Class Cities Law forces the conclusion that any local health ordinance adopted thereunder must in turn be based upon the provisions of the Public Health Law.

In the Smith case there was also a local ordinance to which the Court of Appeals gave no effect. In the Crayton case there was a local ordinance to which the Court of Appeals gave effect. The learned justice who wrote the opinion in the Crayton case states that the later case is not in disagreement with the Smith case. It is a little hard to see how this can be true. However, from a health officer's viewpoint the reconciliation of these two cases is of no importance. The fact remains that the latest decision of the Court of Appeals holds that where a local ordinance provides for isolation or quarantine in any case deemed necessary by the health officer, then so long as the health officer acts in good faith and has reasonable grounds for his action, his action will be sustained, notwithstanding the interpretation of section 25 of the Public Health Law handed down by the Court of Appeals in the Smith case.

This situation emphasizes the importance of having proper local ordinances giving the health officer sufficient power, and adds a further point to the desirability of the universal adoption of the model sanitary code recommended by the Public Health Council. If the health officer in the Crayton case had proceeded

under the provisions of the Public Health Law and not under the provisions of its local ordinance, he would have been liable to damages for false imprisonment, whereas having proceeded under the provisions of his local ordinance he was upheld and exonerated by the Court of Appeals.

3. *Powers and duties of health officers as to nuisances.*—In discussing the problems of a local health officer in relation to nuisances, it is well first to understand exactly what we are talking about. Various evils and conditions are covered by the general term "nuisance." With some of these a local health officer, as such, has no concern. Such are some of the nuisances defined in section 1530 of the Penal Law, the nuisances covered by section 6 of the Public Health Law and the nuisances covered by sections 343-a et seq. of the Public Health Law. Some of the nuisances covered by each of these provisions of law unquestionably may come within the jurisdiction of health boards and officers. But everyone that does come under such jurisdiction is also covered by section 26 of the Public Health Law, and it is with the nuisances covered by this section that we are now concerned.

Section 26 is not as clear as might be desired in reference to what nuisances are covered by it. It provides that the local board of health "shall receive and examine into all complaints made by any inhabitant concerning nuisances or causes of danger or injury to life and health within the municipality." Literally, this might be deemed to include all nuisances but it is a fundamental rule of statutory construction that words must be interpreted in the light of their context, and it will be noted that immediately following the word "nuisances" are the words "causes of danger or injury to life and health." It is my opinion that the nuisances contemplated by this section are nuisances which affect life or health within the municipality, and these only. Otherwise, there would be included within the jurisdiction of public health officials many matters which have not even a remote connection with public health. Witness the provisions of paragraph 3 of section 1530 of the Penal Law which declares to be a public nuisance anything which "unlawfully interferes with, obstructs, or tends to obstruct, * * * a lake or a navigable river, bay," etc. It is, therefore, assumed in this discus-

sion that the jurisdiction of health boards and officers in relation to nuisances are confined to those nuisances which affect the life or the health of human beings within the municipality.

It is possible that within a broad definition of such nuisances might be included *any* matter which might affect the life or health of the community. For example: a person infected with smallpox might very well be deemed to be a nuisance since unquestionably his condition affects the life and health of the community. I do not, however, consider that this was the intent of the law. The specific provisions in other parts of the Public Health Law in reference to control of persons who are afflicted with diseases would seem to indicate that the intent of the Legislature was not to include such persons within the definition of nuisances. Nor is it reasonable to assume that if a person has in his possession an article which through contamination or otherwise, may endanger his health, and his only, that the Legislature intended to include this within the definition of nuisances. The element of danger to the public, to some extent at least, must be present. It would therefore seem that the cause of the nuisance must be something other than a person affected with a communicable disease and that the danger flowing from such cause must threaten some considerable portion of the population. For the purposes of this discussion, I would, therefore, define a nuisance with which a health board or officer is concerned as "a condition of property which injures, or tends to injure, the life or the health of any considerable number of persons within a municipality."

When such a condition is found within a community, it becomes the duty of the health board to take cognizance thereof and to proceed to remedy it. The steps to be taken in general are laid down in sections 26, 31 and 32 of the Health Law and in chapter 6 of the Sanitary Code. There are two ways in which a proceeding against a nuisance may start. The first contemplates a proceeding originating in the board. Either a complaint concerning such nuisance is made to the health board by an inhabitant, or the board itself takes cognizance of an existing nuisance. Under the provisions of section 26 of the Health Law, in either case it thereupon becomes the duty of the local board to investigate the nuisance and it is given authority to

enter upon the premises upon which such nuisance exists and to inspect and examine the same. It may do this either through its own members or through agents or other persons designated for that purpose. The usual course of proceeding is for the board to act in this respect through its health officer. The board, after such examination, is bound to furnish the owner or occupant of the premises with a written statement of the results thereof and its conclusions. If it determines that a nuisance exists, it makes an order for the suppression and removal of the nuisance and it may include in such order a provision that on failure to abate such nuisance the person causing the same shall be liable for a penalty not to exceed $100. (Section 21 of the Public Health Law.) It would seem to me also that it would be wiser in every such order to specify a definite time within which the nuisance must be abated or removed. Section 31 provides that after the service of such order upon the owner or occupant of the premises and the failure upon his part to abate the nuisance, the board, or its agents, may enter upon the premises and suppress the nuisance. For this purpose the board may spend any money which it has in its hands, but the expense of abating such nuisance is made a lien upon the premises upon which the nuisance exists and takes precedence over "all other liens and encumbrances whatever." (Section 32 of the Public Health Law.) To satisfy this lien, the premises may be sold in substantially the same manner as premises are sold for taxes.

This may serve as an outline of the procedure to be followed by boards of heath when nuisances are found to exist within their jurisdiction. It should be noted, further, however, that whenever the State Commissioner of Health is satisfied that a nuisance exists, he may order the presiding officer of the board of health to convene the local board and to take such definite proceedings as the Commissioner of Health deems wise for the abatement of such nuisance, and it thereupon becomes the duty of the board to convene and to take the action recommended by the State Commissioner of Health. This duty, as well as all the other duties thus far outlined, may be enforced by mandamus at the instance of the State Commissioner of Health or of the local board of health, or any citizen of full age residing in the municipality. (Section 37 of the Public Health Law.)

The second method of proceeding against a nuisance originates with the health officer. In addition to the duties which may be imposed upon the health officer by his board of health in the suppression of nuisances, there are to be noted the provisions of chapter 6 of the Sanitary Code. By such provisions it becomes the duty of the health officer, as soon as he receives a complaint in relation to, or knows of the existence of, a nuisance, to make a thorough investigation of the same and to do all in his power to secure its abatement. Within five days of the receipt of the complaint, the health officer must file with the local board the complaint, if made in writing, or otherwise a summary thereof, or if no complaint has been made a statement of the facts, and also his report showing his findings, his opinion as to whether or not the conditions amount to a nuisance likely to affect health, the action taken by him and whether the nuisance has been abated. It is the duty of the board of health, upon the receipt of such report, to convene and to take such steps as may be necessary. These would naturally be the steps provided for in section 26 hereinbefore outlined. After the board has made its decision upon the report of the health officer, the health officer shall within forty-eight hours forward a copy of the decision, together with a copy of the papers filed by him with the board, to the State Commissioner of Health.

The proceeding originating with the health officer necessarily presupposes an investigation and a written report by the health officer and it would seem to be extremely important that, where proceedings originate with the board, the investigations should also be made by the local health officer, and that a written report should be made to the board by the local health officer before any action be taken by it. The reason for this is as follows:

While the board has jurisdiction to determine what is or is not a nuisance, this jurisdiction is reviewable by the courts. Unless the courts find that a nuisance existed as a matter of fact, the proceeding of the board will be overturned and if the board, or its agents, has acted upon such decision of the board, they will be liable for any damages resulting because of their wrongful decision. (*People ex rel. Copcutt* vs. *Yonkers,* 140 N. Y. 1.) This decision is only a sample decision taken from many others to like effect.

As stated heretofore, section 21-b of the Public Health Law provides that the written reports of health officers shall be presumptive evidence of the truth of the facts stated in such report. If, therefore, the local health board, before declaring a thing a nuisance, has in its files a written report of its health officer declaring the thing to be a nuisance, it then has presumptive evidence of the existence of a nuisance and the burden is thrown upon any one seeking to overthrow the action of the board to prove that a nuisance did not exist. This, of course, is of the utmost importance. It is further to be noted that under the provisions of section 21-b, even though the court shall find that no nuisance exists, the individual health officers or inspectors of the board are not liable for any acts done, but that the municipality must bear such liability. This is expressly provided for in said section 21-b, and almost certainly this will be upheld by the courts. (*Golden* vs. *Health Department,* 21 A. D. 420.) If the investigation be conducted by others than the health officer, it is not certain that this immunity would exist.

Care must be taken to distinguish between the acts of a health board in investigating a nuisance and its acts in declaring a nuisance. The former, i. e., the investigation, may be conducted, as heretofore outlined, by health officer or by other employees of the board. The act, however, of declaring a condition a nuisance must be the act of the board and its power in this respect cannot be delegated. (Reports of Attorney-General, 1913, vol. 2, page 482.)

From what has been said in outlining the steps to be taken by a local health board in abating a nuisance, it is clear that the board has the right to enter upon premises and forcibly abate a nuisance after the owner has refused to obey the board's order. It is, however, unwise to adopt this extreme remedy unless the fact that the nuisance exists is unquestionably clear. Otherwise, as has been stated, if the court should afterwards hold that there was not a nuisance the municipality would then be liable for any damages caused. Where there is any doubt it would be wiser to proceed in the courts to obtain the abatement of the nuisance. It is probable that the result desired may be obtained through an injunction proceeding. (*Cahill* vs. *Moran,* 91 Misc. 301.)

There are certain special cases of nuisance, such as those men-

tioned in section 39 and sections 27 to 30 inclusive of the Public Health Law, where health officers and health boards have jurisdiction, but these are so special in their nature and arise as a practical problem so infrequently that it is not deemed wise to enter into a discussion of them at this time.

4. *Powers and duties of health officers in reference to tuberculosis.*—In the first place, before any site for a hospital or camp for the treatment of tuberculosis is established, approval of the site must be granted by a board consisting of the State Commissioner of Health or his deputy and the local health officer. It is the local health officer's duty to sit as a member of such board and his powers and the powers of the State Commissioner of Health, sitting as such board, are equal. Under the provisions of section 320 of the Public Health Law it is the duty of every physician to report immediately any case of tuberculosis. It is the duty of each registrar to report to the health officer the name and address of every person reported to him as having died from tuberculosis. It thereupon becomes the duty of the health officer to ascertain whether or not the physician signing the death certificate had previously reported the case as one of tuberculosis. If he has not, the health officer must call his attention to the provisions of section 320 and in case of repeated violations by any physician the health officer must institute prosecution against him.

Under section 321 it is the duty of the health officer to make, or cause to be made, a microscopic examination of the sputum forwarded to him as that of any person having symptoms of tuberculosis and he must promptly report the result of such examination free of charge to the physician or person upon whose application the examination was made. He must also keep a register in which he shall record the results of such examinations, which register shall not be open to any person other than the health authorities of the state and of the municipality.

Under the provisions of section 323 the health officer must be notified within twenty-four hours when any person having tuberculosis removes from his dwelling or dies therein, and said dwelling shall not be occupied again until it has been thoroughly disinfected under the supervision of the health officer, as provided in section 324. Should the health officer, however, decide that mere

disinfection is not sufficient but that a thorough cleansing and renovation of the dwelling is required, he must notify the owner or agent of the premises to this effect and the cleansing and renovation must be done under the supervision of the health officer. If the disinfection or cleansing and renovating are not done by the owner as required by section 324, it must be done by the local health authorities and the charge for so doing is a lien upon the property. If within forty-eight hours after the giving of such orders and directions the premises have not been disinfected, cleaned or renovated, the health officer must post a sign stating that tuberculosis is a communicable disease; that the apartments have been occupied by a consumptive and that they must not be occupied again until the order of the health officer directing their disinfection has been complied with.

Where any person has tuberculosis and by the disposal of his saliva or otherwise is endangering the people immediately surrounding him, such people may notify the health officer. It then becomes the local health officer's duty to investigate the complaint and if it appears that it is well founded he must serve notice upon the person complained of requiring him to dispose of his sputum in such a manner as to remove all reasonable offense or danger. If such notice is not complied with, the person violating the same is guilty of a misdemeanor. If a complaint be made to a health officer that a person affected with tuberculosis, or other communicable disease, is unable or unwilling to conduct himself and to live in such a manner as not to subject the members of his family or household, or other persons, to the danger of infection, the health officer must immediately investigate the same and if he finds that such person is a menace to others he must lodge a complaint with a magistrate and on such complaint the person shall be brought before such magistrate. The magistrate may, if he believes the complaint is well founded, commit such person to a county hospital for tuberculosis, or to any other hospital or institution suitable, and such person shall not be discharged except in accordance with the rules and regulations of such institution. If the patient neglects or refuses to obey such rules he may be arraigned for disorderly conduct and taken before a magistrate on the complaint of the chief medical officer of the institution.

Where no physician is attendant upon a person having tuberculosis, the health officer must take all proper precautions and give proper instructions for the safety of the individuals occupying the same house or apartment, and perform all the duties of a physician in reference to tuberculosis.

Under the provisions of section 328 it is further the duty of the health officer, whenever a case of tuberculosis is reported to him, to transmit to the physician reporting the case a printed statement and report, in a form approved by the State Commissioner of Health, naming such procedure and precautions as in the opinion of the State Commissioner of Health are necessary or desirable to be taken on the premises of a tuberculosis patient. It becomes thereupon the duty of the physician either to carry into effect all such procedure and precautions and to report thereon to the local health officer, or, if the physician is unwilling or unable to carry into effect the procedure and precautions, to report to that effect. It thereupon becomes the duty of the health officer himself to carry out such precautions and procedure. For this service the health officer is entitled to the sum of one dollar. When the health officer receives a report that the physician is following the precautions and procedure outlined, he shall thereupon investigate and if he finds that such procedure and precautions are being complied with he shall certify to the financial authorities to this effect and the physician shall receive his fee of one dollar. Wherever a health officer deems it necessary he may require the compliance with additional precautions and procedure. He may also cause all reported cases of tuberculosis to be visited from time to time by a public health nurse.

Upon the recovery of a person having tuberculosis, the attending physician must make a report to this effect to the local health officer.

5. *Powers and duties of health officers as to venereal disease.*— All of the powers and duties of health officers in reference to other communicable diseases prevail also in reference to venereal diseases. By a recent act of the Legislature, however (chapter 264 of the Laws of 1918), certain additional powers and methods of procedure were enacted into law.

There is in the new act very little power given to health officers which they did not already have. By making the steps to be

taken definite, however, the Legislature has given emphasis to the powers which local health officers already had and in many cases they have transformed into duties what were before only powers.

The act in question may be said, in general, to apply to three classes of persons: (1) persons suspected by health officers of having a venereal disease and who are likely to be the source of infection to others; (2) persons convicted of various crimes specified in section 343-n of the act which may be generally classified under the head of prostitution; and (3) indigent persons affected with venereal diseases and desiring treatment.

The first two classes may be designated as those who come involuntarily under the provisions of the act; the third class those who come voluntarily under the provisions of the act.

As to those who come under the provisions of the act involuntarily, these provisions, as has been said, apply to two classes of persons: (1) those who are suspected of having venereal disease and who there is reason to suppose are likely to be the source of infection to others; (2) those who have been convicted of any of the offenses prohibited by the law in reference to prostitution. In the first class it is very important for a health officer to remember that jurisdiction to control a person is not conferred upon him merely by the fact of said persons having a venereal disease. There must, in addition, be present the fact that the person afflicted is likely to be a source of infection to others. When such a person is found in a health officer's jurisdiction, or when a person has been convicted of any of the designated crimes, it then becomes the duty of the health officer to cause such person to submit to an examination to determine whether or not venereal disease exists. Such examination may and should include the laboratory examination of blood or bodily discharges. If the result of such examination discloses the presence of venereal disease in either of the two classes of persons designated, then the health officer must see that the person submits to a course of treatment by a duly licensed physician approved by the local health officer or by the State Department of Health. The treatment by such physician must conform with the rules and regulations laid down by the local health board. Such regulations to be effective must first be approved by the

State Department of Health. Under the terms of the act they shall, in general, provide that a person shall submit to such course of treatment; for the manner and duration of isolation, etc. the State Department of Health has provided model rules and regulations which have been submitted to the various local health boards with recommendations for their adoption. It must be remembered, however, that even though a local board of health adopts the exact rules recommended by the State Department of Health they must after adoption be formally approved by the Department before they can be effective. The only effect of the model rules recommended by the Department is to save the local boards the labor of drafting rules which they have to submit to the Department and which probably will be revised and redrafted several times before they are satisfactory. If the board adopts the model rules they can be assured of approval by the Department.

No person suffering with venereal disease and once having submitted to treatment under the provisions of this act can be discharged from treatment until he or she has been cured of the disease.

In the case of a person convicted of any of the designated crimes, they are not to be released from the custody of the court of conviction until they have submitted to the examination herein outlined.

As to persons submitting voluntarily to the provisions of the act.—Whenever a person, whether within any of the two classes discussed or not, has a venereal disease and is unable to pay for treatment, he may apply to the local health board for treatment. The health board must immediately institute treatment and, if, on investigation, they find the person is unable to pay for treatment, they must continue the treatment at the expense of the local health district. This duty of the law is mandatory and not merely permissive and boards of health must provide the treatment therein provided for.

In addition to what has been said, the law also provides that no person, other than a licensed physician, shall treat or prescribe for venereal disease or dispense a drug, medicine or remedy for the treatment of such disease except on the prescription of a duly licensed physician. This applies not only to laymen

but also to all druggists in the state, so that from now on it is unlawful for a druggist to dispense a remedy for a venereal disease except upon the written prescription of a duly licensed physician. When such prescription has been filled, the person dispensing the drug must retain the prescription, give a copy to no one, and fill it only once.

It is further provided that all reports made to, and all information secured by, a board of health in enforcing the provisions of this act shall be strictly confidential except insofar as is necessary to carry out the purposes of the act. Exactly what is the meaning of this last phrase is not clear. It may be assumed, however, that the records of the board are open to inspection by local health officials and by the officials of the State Department of Health. I do not think that under any other circumstances should they be open to inspection by any one, except perhaps in court procedure. If at any time in any court proceeding disclosure of the information in this regard in the health officer's records is considered important, I should advise that no health officer make such disclosure except upon a subpoena duly issued and duly served; that even when he attends court in obedience to the subpoena, he refuse to answer when the question in reference to the records is first put to him and refuse to permit the inspection of the records, pleading the provisions of section 343-r of the Public Health Law. If, however, after such statement on the part of the health officer, the court orders him to make any disclosures, I should then consider that the health officer is released from the prohibition of said section and would be amply proteced in making such disclosures.

In conclusion on this branch I might state that in my opinion no health officer need fear proceeding under the provisions of this new law so long as he acts with reasonable common sense and in good faith. It has been suggested that the law may be unconstitutional. That, of course, cannot be decided until a case has been brought before the court. The reasons for and against its constitutionality could be of no interest to this gathering. Suffice it to say that after a careful examination of all available law on the subject, it is my opinion, as well as the opinion of many other lawyers with whom I have consulted, that the constitutionality of this act will be upheld by the courts.

SMALLPOX AND VACCINATION.

Lecture delivered in the Post-Graduate Course in Infectious Diseases and Public Health for Physicians and Health Officers at the Albany Medical College, April 16th, 1919.

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It seems like old times to come back here to the old lecture room. I am glad to see your familiar faces and I feel quite at home, especially with the dean of this course to introduce me. I am afraid I won't tell you anything fresh on this old theme, but it is fresh to me to say it again, because it is quite a little while since I have spoken on this subject. I want to show you some slides of smallpox and vaccination, but I would like to preface them with a few words on the diagnosis of smallpox, for I intend to confine what I have to say to you this afternoon about smallpox to this practical part of its discussion.

Everybody knows a well defined, well marked case of smallpox; nobody can miss the diagnosis. I think it would be quite impossible, even for one who was entirely uninitiated to mistake it. But in mild smallpox, which we are much more apt to see, the diagnosis is less easy. I think I have never been puzzled more over cases than I have in some that have been the product of Schenectady environment. Dr. Duryee has saved up more than one there which I had to jump the diagnosis on. There are cases which will puzzle, but I would remember this about it that smallpox is a very decent disease in that it always plays the game; you can always trust it to run its course in an orderly way and to express itself by certain well defined symptoms, which to some degree will be present in even very mildly expressed cases. And let me say in this connection that mildness of expression is diagnostic of smallpox so far as eruption is concerned. Ask yourselves if you have ever seen a case of chickenpox with so few as twenty or thirty lesions; but you may find smallpox cases with less than half a dozen and these ill defined.

Reverting, for analogy, to our country experience I would say that a diagnosis will like a milking stool generally stand on three legs. The gist or substance of what I have to say to you now is

contained in three cardinal points of diagnosis which are fairly pathognomonic and, to some degree, characteristically present in every case. I will give them in the order of their diagnostic value.

First: The mode of onset or initial fever. That of smallpox is peculiar to it, not found in any other disease. It begins like an ordinary cold. A man awakes in the morning feeling a little indisposed, but not out of sorts enough to stay away from his work. Very likely in the afternoon he will stay at home and toward night will have headache and rachialgia with general indisposition more marked. Next day the symptoms will be intensified and the more as the day goes on, very likely feeling worse during this time and till the next day than at any time of the whole course of his disease. Then sometime on the third day a rash will develop on his face and before night he will begin to feel decidedly better; there will be a rather abrupt abatement of his sensation of illness. Here are phenomena, I think you physicians all know, not found in any other ailment whatever: A gradual onset, increasing intensity, rather abrupt abatement as eruption appears. It is singular to smallpox.

Second: Will be the distribution of the eruption. This will always come first on the uncovered part of the skin, the face and hands; and it will always be more abundant there. Take note of this when you see the slides. Contrast the face with the chest, where even in a confluent smallpox there may be comparatively little eruption; and compare it with chickenpox where the converse is the case. At the same time note that on a given locality all the lesions will appear within twenty-four hours so that all adjacent lesions will be of the same age and size or stage of development; and all of the entire body will appear within forty-eight hours. Here again contrast this with chickenpox, where there are new lesions coming continuously alongside of old ones for five days, so that you find small new ones adjacent to those which came three or four days ago and are fully developed. There are likely to be lesions also on the back of the hands which will help in diagnosis from acne; also on the palms, and likewise on the roof of the mouth in cases of enough severity, but so may there be in chickenpox. The eruption will be grouped.

Third: The morphology of the lesion; this is the symptom usually first questioned for a diagnosis but should be the last. The type lesion of smallpox is a deep-seated papule. At its very earliest it will be a *red* macule, very soon developing the solid elevation which then and later your finger tip will make you sensible of more than your eyes and distinguish it from the congested base of a chickenpox lesion. You will find these about the central part of the face or the forehead. The red areola seen about the chickenpox lesion will not be present. On the face and limbs this type of papule will exist; it will not be so marked on the body. It will characterize the lesion in all cases; but in mild cases it may abort, develop no further. In ordinary cases serum will appear in the apex of the papules in a few days, eventually becoming pustular; but very often it stops short of this, the vesicle dries up, but the deep papule will continue for the term of the disease. The vesicle of smallpox is almost stony hard, unlike any other, being chambered.

Let us apply these three symptoms to a mild case. There is a sparse and indefinite lesion. Let the patient tell his own story. Often without prompting he will narrate a course of symptoms such as I have given; otherwise ask him when the eruption appeared and where; then as to his sensations that day, the day before and the day before that. It may be that it has been so mild that he has never given up his work, but you can get some approach to a three-day onset even if it is only a headache and mild malaise. Many have had no more than this, found in factories or on the highway at their work or in public conveyances, all to a modified degree infectious. Traces of the lesion can be found on them for a considerable time, remnants of the hard papule or stains left. One who has such a mode of onset, such a distribution of the lesions, and such a papular eruption has smallpox.

Now we will look at the lantern slides. First we will have a series of views of the eruption showing it from day to day in an unvaccinated man; beginning with the third day of eruption. The face is shown and is closely covered with papules which have broadened so as to involve most of the face. We will see the identical lesions as they develop. Fourth day: the papules

have enlarged and are becoming vesicular as were some in the last view; notice that while most of the skin is involved there is a grouping of lesions and areas that are free. Sixth day: all the lesions have become vesicular, of the size and shape of a split pea, tensely full and almost stony hard to touch. Eighth day: height of the eruption, the vesicles have become turbid pustules, some have run together, the face is swollen, the fever of suppuration is at its highest. Tenth day: not much change except that a few of the earliest lesions are drying; and this is quite marked as seen on the next slide of the twelfth day. Sixteenth day; desiccation is well under way and the subject is going on toward convalescence; and the final picture is after recovery showing scars and the baldness from involvement of the scalp. Vaccination would have saved all this.

This slide showing a young girl at the eighth day of eruption is a good illustration of several points in diagnosis; the eruption is abundant on the face and hands and sparse on the chest; grouping of lesions is characteristic; lesions are of one size except that some have run together.

In this next slide we see the distribution of eruption on the entire nude body; on the face abundant, on the limbs considerable, on the chest very little.

This negro subject of severe smallpox at the eighth day has confluent eruption on the face, semiconfluent on the limbs and discrete eruption on the trunk.

In all these cases there were lesions on the roof of the mouth and on the palms and soles as well as on the scalp; the same will however occur in the case of chickenpox and is not diagnostic.

This is a case of discrete smallpox showing scattered lesions on the face in the healing stage with large crusts covering them, a mild case. There are probably few lesions elsewhere. These thick, dry crusts are unusual.

Here is an illustration of exceedingly mild smallpox: on this young woman's face there are not more than half a dozen lesions with one here and there on the arms, and they are evidently not going beyond the papular stage. Still though vesicle may not form and the lesion abort as it were they will continue for a

considerable time as firm papules so that they may be detected for two weeks. Many of these mild cases occur; apply to them the three guides to diagnosis, they will be found in some degree. I once saw an undertaker who gave a history of onset as already outlined who had so far as I could discover only a single papule on the face; two weeks before he had buried a body dead from smallpox. These very mild cases must be only moderately infectious, for not a tithe of those whom they come in contact with contract smallpox, which ordinarily is as infectious as measles.

Chickenpox, fourth day of eruption: the lesions here are superficial vesicles; of various size from finger-nail to pin-head and these side by side; covering thickly the chest with little on the face; the largest came four days ago along with a little fever, the smallest came today; the oldest are already desiccating. Tomorrow new ones will appear but will mostly not develop, and all will in a few days dry, the thin crust fall, leaving only a stain, not the tangible papule that lingers on in the mild smallpox.

Chickenpox in an adult: Not infrequent up to the age of thirty; usually they will have some initial fever and more illness during the course. The eruption is more abundant on the upper back than elsewhere. If in any case there are only half a dozen lesions the case is smallpox rather than varicella, in which there would never be less than thirty lesions — there may be thousands covering thickly the entire body yet the subject moderately ill; with a body so covered with smallpox he would be moribund.

A child with measles: the body covered with dull red macules; the coryza which characterized the four-days fever of onset still apparent; Koplik spots still probably in the mouth. There is no resemblance to the papules of smallpox but often they are confounded.

Occasionally smallpox is confused with impetigo, acne, scabies, multiform erythema; but it may more likely be with the papulopustular syphilide and with difficulty distinguished when a satisfactory history cannot be gathered, for the lesions and their distribution can be identical.

Here is the picture of Edward Jenner. On May 14, 1796 after he had for 25 years followed up the remark of a dairy maid,

"I will not take the smallpox for I have had the cowpox," he innoculated a lad with lymph from a sore on a dairy maid's hand which she had contracted from lesions on the udder of a cow having cowpox, and then established that he was fully immune to smallpox. This meant the potential saving of 600,000 lives a year; surely he was one of the great benefactors of humanity.

Here is a slide showing three children: they were brought to the hospital with their mother who had smallpox as did also the youngest child; the two older of kindergarten age had been vaccinated and escaped, and although in the hospital for weeks did not take the disease. School vaccination has certainly saved many and should be required by law.

Here are two sisters who have been exposed to smallpox: one vaccinated in infancy has now at the age of 14 a slight varioloid while the other never vaccinated has severe smallpox. I recently saw a newspaper account of a family in Chicago who had been exposed to smallpox and the only one vaccinated was a man eighty years old who had been vaccinated in infancy who alone escaped. No one can say how long immunity continues after vaccination. But I think that a very considerable number, I have sometimes thought 50 per cent, are protected for life by one vaccination. Does anyone doubt the efficacy of vaccination? For years I was in the way of coming in contact with smallpox constantly and this was my only protection. Some of you have put it to similar test.

This slide shows an eighth day vaccination. I show it to say that while a female infant might be vaccinated up over the deltoid muscle where the scar will perhaps be less conspicuous as a rule it should be done at the insertion of the deltoid; do not vaccinate over a muscle because use of the muscle will make pressure on the lesion and cause irritation. Also don't make two insertions so close together; they should be an inch and a half apart and the second over the posterior edge of the muscle. Multiple vaccinations are justifiable for the sake of assurance of success where a person has been exposed to smallpox.

As to the technique of vaccination: after the site has been washed with soap and water, then with alcohol and then with

sterile water, a single tear one-fourth inch long should be made with sterile needle or scalpel through the scarfskin only down to the lymph spaces of the rete; cross hatching is not allowed. Vaccination by puncture appears to me a good way, done as follows: the virus is expelled on the arm and minute punctures through it made with the instrument held almost parallel with the surface, the virus being then wiped off down the line of puncture.

The best dressing is a clean fresh washed and ironed handkerchief pinned to the sleeve, or a fold of sterile gauze held on with a strip of adhesive plaster. Cleanliness and avoidance of handling are the chief protection. In almost every case of bad result that I have seen the cause has been from lack of this.

This legend tells who not to vaccinate. "Any one well enough to go to school is well enough to be vaccinated." Any one recently exposed should be vaccinated regardless of condition. A mother in Utica developed smallpox a week before giving birth to a child; the child was vaccinated when two days old with success and no untoward result. Near the same time I saw a baby fatally ill with smallpox whose mother had mild, unrecognized smallpox just before its birth. Generally vaccination should be deferred in one having acute skin eruption such as eczema. Jenner said that any vesicular eruption was a contraindication. A fair condition of health will conduce to a more orderly result. Vaccination is protective if it has reached its eighth day, while smallpox will not develop until twelve days after exposure.

Let me read you an interesting advertisement which I have found, from a copy of *The Albany Register* of July 13, 1813.

VACCINE MATTER.

"The subscriber having been appointed by the President of the U. States Agent for Vaccination hereby gives notice that GENUINE VACCINE MATTER will be furnished to any physician or other citizen of the U. States who may apply to him for it. The application must be made by post, and the requisite fee (five dollars) in the current bank paper of any of the middle states forwarded with it. When required such directions, etc., how to use it, will be furnished with the matter as will enable any discrete person who can read or write to

secure his own family from the smallpox, with the greatest certainty, and without any trouble or danger.

All letters on this subject to or from the undersigned, and not exceeding half an ounce in weight, are carried by the U. States mail free of postage, in conformity to a late act of Congress, entitled 'An Act to Encourage Vaccination.'

"All newspapers in the U. States are requested to publish the above once a week for three weeks and payment for the same will be made.

"JAMES SMITH,
"*U. S. Agent for Vaccination,*
"Baltimore."

In this connection let me give you a little personal history. In the spring of 1869 when I was a third-year medical student, in New York, a house-to-house canvass of that city for vaccination was made, and I received an appointment on the work. I could tell an interesting story of my experiences for I was assigned to serve under a health inspector whose district took in all between Broadway and Bowery from Houston Street to the old Five Points, and we were expected to visit every family, ascertain whether they were vaccinated, and vaccinate all who were willing to be. The work was under the direction of Dr. Elisha Harris who met us in weekly conferences; he was an enthusiast in vaccination. When, in 1880, the State Board of Health was established Dr. Harris was made its executive head here in Albany and very naturally I renewed my acquaintance with him; soon he asked me to assist him and I began the congenial connection with that Department which, for many years quite active, has been unbroken till now. This is a lengthy introduction to an episode in this subject in which I had a minor part. Up to 25 or 30 years ago humanized virus was almost solely used either by arm to arm vaccination but more generally with the dried crust. There were no general purveyors of vaccine. In 1871 Martin, of Boston, began the propagation of animal lymph. About the same time the New York Dispensary established an animal vaccine service of which Dr. Frank P. Foster, long editor of the *New York Medical Journal,* was made director for a time experimentally and later for distribution. He maintained it, from a start with the Beaugency stock,

through an unbroken series of calves. It was his desire to introduce this to the profession through selected individuals rather than retail apothecaries and I became his agent here through Dr. Harris. I have and prize his first letter written in 1882 in which he tells of his work and the virus. He had for reasons he does not give become dissatisfied with quill slips and instead used slips of wood covered with some sort of glazing to keep the lymph from sinking into the wood. There was then no thought of treating the virus with glycerine and the lymph was collected directly from the fifth day vesicles of the calf, which he certainly did with scrupulous care. These when dry were fastened on cards of twenty and enclosed in air-tight wrappers. He directed that the slip be moistened with cold water, the epidermis scraped, not cut or scratched, with a lancet and the moistened lymph rubbed in for a minute or more. No mention was made of washing the skin, or using sterilized water; disease germs had not come much into evidence in the earliest '80s. The virus was effective, but worked rather harshly. It took a good while to get doctors to pay 20 cents for a vaccine slip when they could get a good crust of their own collecting from an arm and perhaps carry it around in a wallet for months ready for use.

It has been said that Bovine Virus is more effective than that long humanized but Dr. Harris and I about this time obtained some from Dr. Snow, of Providence, who was maintaining a series of human vaccinations, developed from a stock which he secured from the Jennerian Society of London, which had kept an unbroken series of arm-to-arm vaccinations with virus received direct from the hand of Jenner. This long humanized virus I found working uniformly and normally, causing moderate reaction and always showing the typical oval, amber-colored crust and foveated scar, and I never had reason to doubt its efficacy.

Editorial

"IN ALL THEIR AFFLICTION HE WAS AFFLICTED
AND THE ANGEL OF HIS PRESENCE SAVED THEM."

TO THE GLORY OF GOD
AND
IN MEMORY OF
HELEN FRANCHOT DOUW
THIS BUILDING IS ERECTED
BY HER HUSBAND
J. TOWNSEND LANSING
A. D. 1898

So reads the tablet dedicatory of Pavilion D of the Albany Hospital. By his death the building becomes a memorial to the husband as well as to the wife, and bears a double significance in its tribute to the character of the donor. A long life of benevolence is symbolized in the unwitting revelation of the guiding impulse to relieve suffering, particularly poverty and sickness. It was the warp and woof of his nature, and through all his activities, and they were many, commercial, social, civic, ran this thread of intense, unobtrusive, human sympathy. It found its ultimate demonstration and its greatest opportunity in the medical institutions of the city, the hospital, the college and the laboratory, with which Mr. Lansing became most intimately identified, and to which he gave the best energies of his later years. In 1897 he became a governor of the Albany Hospital, and in 1904 its president. The fifteen years of his administration were years of evolution of eleemosynary institutions, and growth of this kind, not only in physical structure, but in the progress and change of scientific thought and of medical and surgical practice, is inevitably involved in difficulty and doubt. Physicians are said to be pugnacious. This is in some measure true. The daily contest against the foes of health, the sudden and unexpected demands upon resourcefulness and rapid action, faith in personal experience, all tend to the development of aggressive personality. Pride of opinion and sensitiveness to censure are the inevitable

J. TOWNSEND LANSING

Albany Medical Annals
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effects of their training. The piloting of a growing hospital through the shoals of conflicting theories, discrimination between enthusiasm and error, prevention of bitterness and resentment, are no small part of the task of the executive of such an institution. As the hospital grew Mr. Lansing grew with it. The position he held may in many ways be regarded as the highest to be attained in the city of Albany. Its incumbent becomes such only by merit, and by a process of gradual selection. By his moderation and courtesy, by his unvarying responses to every call of duty, by his gentle firmness, Mr. Lansing was an ideal president, and to the high responsibility of the office he assumed, has been added the dignity he imparted to it.

As a Trustee of the Albany Medical College Mr. Lansing comprehended and promoted the effort to coordinate the school and the hospital into a combined institution of medical education and research. His experience with doctors and practical medicine had freed him from whatever prejudices, as a layman, he might have held against the use of the wards for teaching, and he saw and realized the benefits of research and study as stimulating the best efforts and promising the best results, not only for the institution but for the patients themselves. His efforts in this were grounded in faith in Albany as an educational centre, and when existence of the College was threatened by the need of more expensive equipment, radical changes in methods, and later by the stringency of the war, he was one of the few whose hope never faltered, and before his death he had the satisfaction of seeing the promise of restitution and of realization in the near future of the ideals he had cherished.

One wonders why a man whose life is laid in conditions of ease and comfort should burden himself with wearing and persistent responsibilities; should voluntarily enter upon scenes of contention and difficulty, when all sources of friction might be avoided; should engage in tasks, too often unrequited, and too often misinterpreted, when a path of simple ease might be chosen. The only answer is the presence of some inherent, God-given goodness. In Mr. Lansing it was plainly a sense of duty. He sought no fame and he asked no reward. He was sometimes pained that his unselfish efforts were subjected to the crude and

unprincipled criticism or attacks of cheap seekers for personal advantage, but he allowed these casual incidents no weight in his determination to proceed upon his own judgment. And so, as the events of his life gradually shaped themselves, he was directed by the force of circumstances and by the involuntary reaction of his nature, to the place he was best fitted to occupy, and to the realization of the purpose he was plainly destined to perform as a benefactor of his kind. No one knows what were his private charities. It is not necessary that they be known. He guided the advance, by intimate personal acquaintance with its details, of a large hospital. He shaped the policies of its administration, he arbitrated the differences of medical opinion of its staff, he encouraged and promoted the best professional sentiment of its nurses. The ultimate influence of such high purpose is beyond estimate. The good things that he did will live long after him, and streaming out in countless channels will give comfort and relief to countless sufferers.

Mr. Lansing allowed himself only one indulgence. He was a lover of the beautiful in art. His large collection of paintings was frequently exhibited in the Historical and Art Society for the pleasure of the public. He enjoyed displaying these treasures to friends in his home, and he seemed to have obtained them for the delight of others. And so his avocations became the objects of his life, and his commercial interests, though carefully managed, were subordinate. He was, in the exact meaning of the word, a philanthropist.

There are traditions of communities whose character and purpose are typified in one individual. The fact of such an incarnation is as rare as the fiction is agreeable. If a stranger in Albany were to have asked, at any time during the last ten years, where might be found the man who best typified the thought, feelings, history and ambitions of this old city, there might have been pointed out to him the unassuming gentleman of this sketch, walking rather rapidly and in meditation from one to the other of his numerous appointments. The simplicity of his manner, his cordiality, his inquisitiveness into detail, his manifest desire to obtain all the information necessary to correct judgment, gave evidence of single-mindedness and integrity. The medical pro-

fession of Albany owes much to Mr. Lansing, the city more. He reached perfection, in so far as a human being may reach perfection, in his demonstration of fidelity to the good, the true and the beautiful.

Public Health

Edited by Arthur Sautter, M. D.

DEPARTMENT OF PUBLIC SAFETY, BUREAU OF HEALTH, ALBANY, N. Y.

COMPILED BY WILLIAM F. FULLGRAFF, REGISTRAR.

BUREAU OF VITAL STATISTICS.

DEATHS FOR THE MONTH OF JULY, 1919.

Consumption	8	Bright's Disease	16
Typhoid Fever	1	Apoplexy	7
Scarlet Fever	0	Cancer	15
Whooping Cough	3	Accidents and Violence	10
Measles	0	Deaths under 1 year	8
Diarrheal Diseases	3	Deaths over 70 years	30
Pneumonia	1	Death rate	11.25
Broncho Pneumonia	1	Death rate, less non-residents	9.20

Deaths in Institutions.

	Non-res.	Res.		Non-res	Res.
Albany Hospital	14	6	Public Places	1	3
Albany Hospital Camp	0	1	St. Margaret's House	2	0
Albany County Hospital	0	1	St. Peter's Hospital	5	2
Federation of Labor Camp	0	1		31	22
Homeopathic Hospital	5	5			
Home for the Aged	0	1	Births		148
Hospital for Incurables	3	1			
Maternity Hospital	1	1	Still Births		4

DIVISION OF COMMUNICABLE DISEASES.

Typhoid Fever	3	Tuberculosis	18
Scarlet Fever	13	Mumps	10
Diphtheria and Croup	3	Pneumonia	9
Chickenpox	5	Influenza	0
Smallpox	0	Septic Sore Throat	9
Measles	33	Cerebro Spinal Meningitis	2
German Measles	0		
Whooping-cough	11	Total	116

Number of days quarantine for scarlet fever:
Longest..... 57 Shortest..... 30 Average..... 35½
Number of days quarantine for diphtheria:
Longest..... 42 Shortest..... 15 Average..... 22
Fumigations
Rooms ..... 141 Buildings 94
Milk bottles disinfected 670

Miscellaneous.

Cards posted for communicable disease	34	Inspections and reinspections	40
Cards removed	82	Vaccinations	3
Notices served on schools...	0	Vaccination dressings	11
Notices served on stores and factories	34	Children examined for employment certificates	129
Postal card returns sent to doctors	34	Number of employment certificates issued	129
Postal card returns received from doctors	34		

Tuberculosis.

Living cases on record July 1, 1919.....		864
Cases reported:		
By card	14	
Dead cases by certificate.....	4	18
		882
Dead cases previously reported	4	
Dead cases not previously reported.....	4	
Removed	2	10
Living cases on record August 1, 1919.....		872
Total tuberculosis death certificates.....		8
Visits to cases of tuberculosis.....		27
Miscellaneous visits		25

Laboratory Report.

Diphtheria.

Initial Positive	11	Unsatisfactory	10
Initial Negative	227		
Release Positive	30	Total	348
Release Negative	70		

Sputum for Tuberculosis.

Positive	41	Unsatisfactory	0
Negative	116		
		Total	157

Widals.

Positive	2	Unsatisfactory	1
Negative	20		
		Total	23

Meningococcus.

Positive	0	Water analyses	2
Negative	0	Pathological examinations	0
		Gonorrhea examinations	53
Total	0	Miscellaneous examinations.	0
Wassermann tests	233	Total examinations	1,061
Milk analyses	245		

Division of Sanitation.

Complaints	91	Reinspections	93
Inspections	80	Plumbing	23
Plumbing	21	Sanitary	70
Sanitary	59		

Hearings.

Hearings	3	Cases heard	3

Class of Cases.

Filthy premises	3

Division of Plumbing, Drainage and Ventilation.

Inspections	123	Smoke	0
Old houses	61	Blue or red	2
New houses	62	Peppermint	3
Permits issued	67	Water test	9
Plumbing	59	Houses examined	34
Building	8	Re-examined	95
Plans submitted	27	Valid	26
Old buildings	11	Without cause	8
New buildings	16	Violations	0
Houses tested	14		

REPORT OF REMOVAL OF DEAD ANIMALS.

Horses removed	9	Cats removed	97
Dogs removed	24		
		Total	130

DIVISION OF MARKETS AND MILK.

Public market inspections	26	Milk cans inspected	416
Market inspections	88	Milk cans condemned	0
Fish market inspections	9	Lactometer readings	107
Fish peddler inspections	0	Temperature readings	107
Slaughter house inspections	3	Fat tests	0
Rendering establishment inspections	0	Sediment tests	46
		Chemical tests	0
Pork packing house inspections	2	Cows examined	652
Hide house inspections	0	Cows quarantined	0
Milk depots inspected	16	Cows removed	12
Stores inspected	47	Complaints investigated	0
Dairies inspected	59	Milk houses inspected	59

Medical News

THE ALBANY GUILD FOR PUBLIC HEALTH NURSING.—STATISTICS FOR JULY, 1919.—Number of new cases, 107; classified as follows: Charity cases, 19; cases, moderate income, 37; metropolitan, 51; prenatal (no charge for call), 20; dispensary, social service, 70; tuberculosis, 29; cases carried from last month, 136; total number of cases under care during month, 469. New cases classified according to diseases: Medical, 42; surgical, 17; obstetrical (a) prenatal, 20; (b) confinement, 29; (c) maternity, 2; no diagnosis. Disposition: Removed to hospital, 7; died, 7; discharged cured, 72; discharged improved, 10; discharged unimproved, 0; discharged to other care, 16; to dispensary, 1; number of patients still under care, 239. Cases reported by: Physicians, 31; metropolitan, 38; patients, families or friends, 23; nurses, 10; homeopathic social service department, 10; other sources, 2; dispensary, 4.

Special Obstetrical Department.—Number of obstetricians in charge, 0; number of students in attendance, 0; number of new cases this month, 0; number of nursing visits, 0.

Visits of nurses (all departments).—Number of visits with treatment, 940; number of social service, 115; number of prenatals, 68; number of tuberculosis, 70; number of other visits, 101; venereal calls, 9; total number of visits, 1,409.

Metropolitan Report.—Number of metropolitan calls, 306; checks received for last month's calls, $242.40.

Monthly Report.—Number of clinics held, 69; number of new patients, 63; number of old patients, 445; total number of patients treated during month, 508. Classification of clinics: Prenatal, 4; surgical, 14; nose and throat, 7; eye and ear, 14; skin and venereal, 8; medical, 8; tuberculosis, 5; dental, 0; nervous, 0; children, 1; gynecological, 8. Special tuberculosis department: Number of new patients, 29; number of dispensary patients, 12; number of patients sent to hospitals, 9; number of patients returned from hospitals, 3; number of patients dead, 29; number assisted with milk and eggs, 3.

Tuberculosis Report.—Total number of new patients, 29; dispensary, 12; other sources, 17; total number of calls, 70; number of patients sent to hospitals, 9; number of patients returned from hospitals, 3; number of patients died, 29; number of patients assisted with milk and eggs, 3.

Dispensary Report.—Number of clinics held, 5; number of new patients, 12; number of old patients, 6; total number, 18; number of prescriptions, 7; physicians attending: Dr. Hawn, 4; Dr. Faust, 1.

Hospital Social Service Report.—Number of cases investigated, 26; number of calls to hospital wards, 10; number of calls to dispensary, 3; number of co-operating calls, 4; number of calls to patients' homes, 28. Disposition of cases: Referred to Associated Charities Department, 1; reported to private physician, 2; referred to general nursing service, 1; referred back to dispensary, 2; discharged, dead, 1; discharged to reformatory, 0; discharged to tuberculosis department, 1; discharged O K to go home, 11; discharged, Home for Feebleminded, 0; discharged, moved out of town, 1.

Kinematic Surgery in Military Hospitals.—Remarkable results have been achieved in Italian Military Hospitals recently by the use of what is known as "kinematic surgery" the invention of Professor Putti of Bologna university. Professor Putti's methods have aroused intense interest on the part of American doctors attached to the Balkan Commission of the American Red Cross who are supervising the artificial leg factories already established and being established in Athens, Salonica, Belgrade and Bucarest for the war's mutilated.

At the present moment the Allied soldiers in the Balkans who have lost their limbs are being fitted with artificial legs and arms of a type similar to that employed by Sarah Bernhardt. Prof. Putti's methods, however, are a distinct advance over all other artificial appliances.

His treatment of amputated limbs consists of a unique preparation of the stump to develop a "motor" end to the cords which, after being bound together over a smooth "bearing" of bone, get as much as a three inch travel of the leg by means of a reeducation and coordination of the muscles of the stump.

After the stump heals, Professor Putti cuts out a flap of flesh which he folds back into an incision to take the flap. This is allowed to heal and

then, through the loose flap of flesh, a metal bar with attachments to operate the artificial limb below is suspended.

The muscles of the calf and thigh readily respond after some weeks to the movement of the artificial leg and soon the pressure of the swinging of the artificial leg reeducates the muscles through the flap of flesh so that it may be said that the muscles of the stump actually operate by themselves the mechanical features of the artificial limb.

In case of a severed hand the muscle groups surrounding the bone are trained to operate catgut cords, which in turn, operate artificial fingers. Not since the introduction of "debridement" in American Army medical work in France has any medical innovation created so much comment.

"Typhus Train" Aids Russian Refugees.—A specially equipped "typhus train" financed by funds supplied by the Interallied Sanitary Commission and managed by the Red Cross, has ravelled from Vladivostok to the Ural Mountains, its staff of doctors and nurses ministering to persons afflicted with the malady and instructing the people in preventive measures. At the present time this train is operating among the soldiers of the Kolchak government on the Perm front. Many carloads of drugs and medical supplies have been provided for the men of the Russian army. A special Red Cross mission which recently made a survey of the situation in western Siberia found that many of the hospitals had been stripped of drugs, instruments and surgical dressings. The Red Cross is equipping these institutions. In all, about forty tons of drugs have been shipped from America since last September.

About 1,500 refugees remain in and around Vladivostok and these have been concentrated in barracks a few miles outside of the city. Labor is in demand around Vladivostok and this fact has greatly reduced the number of refugees.

Dr. Garvin Decorated for Services in France.—Major Albert H. Garvin chief of the Bureau of Tuberculosis, Medical and Surgical Department with the American Red Cross forces in France, has been decorated with the Medaille d'Honneur de Vermeil of the French government in recognition of his services to that country. Major Garvin, who went to France in September, 1917, was superintendent of the New York State Hospital for Tuberculosis for ten years. He returned to America late in June.

Personals.—Dr. Henry L. K. Shaw (A. M. C., '96), 361 State St., Albany, N. Y., announces his resignation as Director of Child Hygiene of the State Department of Health and will devote his entire attention to the prevention and treatment of diseases of children in private practice.

—Dr. Clarence J. Slocum (A. M. C., '97), announces a reorganization in the management of Craig House, a private hospital for nervous and mental cases, at Beacon, N. Y. Dr. Robert B. Lamb (A. M. C., '91) retired from the organization on July 1st, and his interest has been ac-

quired by Dr. Edward G. Stout (A. M. C., '96), recently senior assistant physician at the Utica State Hospital.

—Dr. Walter H. Conley (A. M. C., '91), is General Medical Superintendent of the Department of Public Charities, New York City, with office at Blackwell's Island.

—Dr. Paul V. Winslow (A. M. C., '08), is now in practice at 616 Madison Avenue, New York City.

—Dr. Orla A. Druce (A. M. C., '09), has removed his office to 542 Central Avenue, Albany, N. Y.

—Dr. John S. McCormick (A. M. C., '14), has removed his office to 508 Madison Avenue, Albany, N. Y.

—Dr. Raymond F. Kircher (A. M. C., '17), after service in St. Francis Hospital in Westport, Conn., has opened his office at 5 DeWitt Street, Albany, N. Y.

—Dr. William J. Wansboro (A. M. C., '95), after returning from military service, has resumed general practice at 226 Lark Street, Albany, N. Y.

—Dr. Robert B. Lamb (A. M. C., '91), formerly Physician in Charge of Craig House and President of Craig House Corporation since its organization, announces his withdrawal from these services and will receive a limited number of selected patients for care during the summer months at "Onawaawek," Chazy Lake, in the Adirondacks.

Married.—Dr. John Hourne Robertson (A. M. C., '17) and Miss Jean Tait, formerly instructor in biological chemistry in the Albany Medical College, were married June 19, 1919, at the residence of the bride's parents, East Haven, Conn. Dr. and Mrs. Robertson will live in Johnson City, N. Y.

In Memoriam

Charles Frederick Myers, M. D.

Dr. Charles Frederick Myers, a graduate of the Albany Medical College of the year 1910, and Dr. William P. Sweeney, of the class of 1915, suffered violent deaths on the morning of July 30, 1919, in an automobile accident in New Scotland avenue, Albany. The machine struck a rut, swerved across the street, crashed into a tree and was demolished, with frightful mangling of the victims and probably instantaneous death.

After graduation Dr. Myers served as interne in the Albany Hospital, and then engaged in general practice in the city of Albany. He was an attending surgeon at St. Peter's Hospital, and was coroner's physician of the county of Albany. Dr. Myers is survived by his wife.

William P. Sweeney, M. D.

Dr. Sweeney died in the automobile accident which was fatal to both himself and Dr. Myers. Dr. Sweeney was a native of Saratoga, gradu-

ated in 1910 from the Saratoga High School, and in 1915 from the Albany Medical College. He was an interne in the Bellevue Hospital, and in 1916 enlisted for immediate overseas duty in the British Expeditionary forces. On Christmas Day, 1917, he returned to America, and afterward received a first lieutenant's commission in the United States army and went to France. He was later promoted to the rank of captain. The accident which caused Dr. Sweeney's death occurred five days after his discharge from military service, and he was on his way to his home when he stopped for the visit with Dr. Myers. Two sisters and a brother survive him.

Dormar Baldwin, M. D.

Dormar Baldwin, M. D., a graduate of the class of 1877 of the Albany Medical College, died at his home in Oneonta, N. Y., on June 26, 1919.

Dr. Baldwin began active practice of medicine at South Worcester, N. Y., immediately after graduation, and in 1880 removed to Jamestown, N. D., where he remained for twenty-seven years. He then returned to New York, and retired from practice after having made his residence in the city of Oneonta. He had a large and varied experience in Dakota when it was a territory with a scattered population and only small towns and no cities. He was appointed a surgeon for examination for soldiers' pensions in 1880, and afterward became a member of examining surgeons for pensions, which position he held until 1908, when he resigned. Dr. Baldwin was born in North Blenheim, N. Y., in 1848. He married Miss Flora Shearer, of Oneonta, N. Y., in 1905. There were no children.

NEW YORK STATE MEDICAL LIBRARY

Edited by Frances K. Ray.

Evening Opening—With the beginning of the college year, September 22d, the Medical Library will resume full evening service, opening from 9 a. m. to 10 p. m. daily, except Sundays.

New Books which come to the library from time to time on approval will be on exhibition at the librarian's desk for a limited period after the receipt of each shipment. Physicians are invited to inspect them and those interested in the selection of books for this library will confer a favor by giving the librarian an estimate of their value for purchase.

Publishers' catalogs and book review notes are always on file, available for consultation by any one seeking information for personal use.

Will there be another epidemic of influenza?

ARE we to have a recurrence of the plague which destroyed half a million lives in this country a year ago? In all probability, yes. A review of the records of previous epidemics warrants the assumption that the scourge will reappear the coming fall and winter.

In the event that this theory proves correct, how can the medical profession cope with the disease?

Prophylactic vaccination is the rational procedure. In support of this contention we cite two illustrations:

In one locality, during the recent epidemic, 3437 persons were immunized with Influenza-Pneumonia Vaccine (Prophylactic). Of this number only six died, and these had but one injection. Among those who received two or three injections there were no deaths.

In another locality 800 persons were immunized: 481 received one inoculation, 224 received two, 95 received three. Only twenty cases of influenza developed among those who had one or more inoculations. But two deaths occurred, and these were of persons who had only one inoculation.

As a prophylactic the vaccine is administered in three graduated doses at intervals of three or four days. The first dose is two and one-half billions (½ mil); the second, five billions (1 mil); the third, seven and one-half billions (1½ mils).

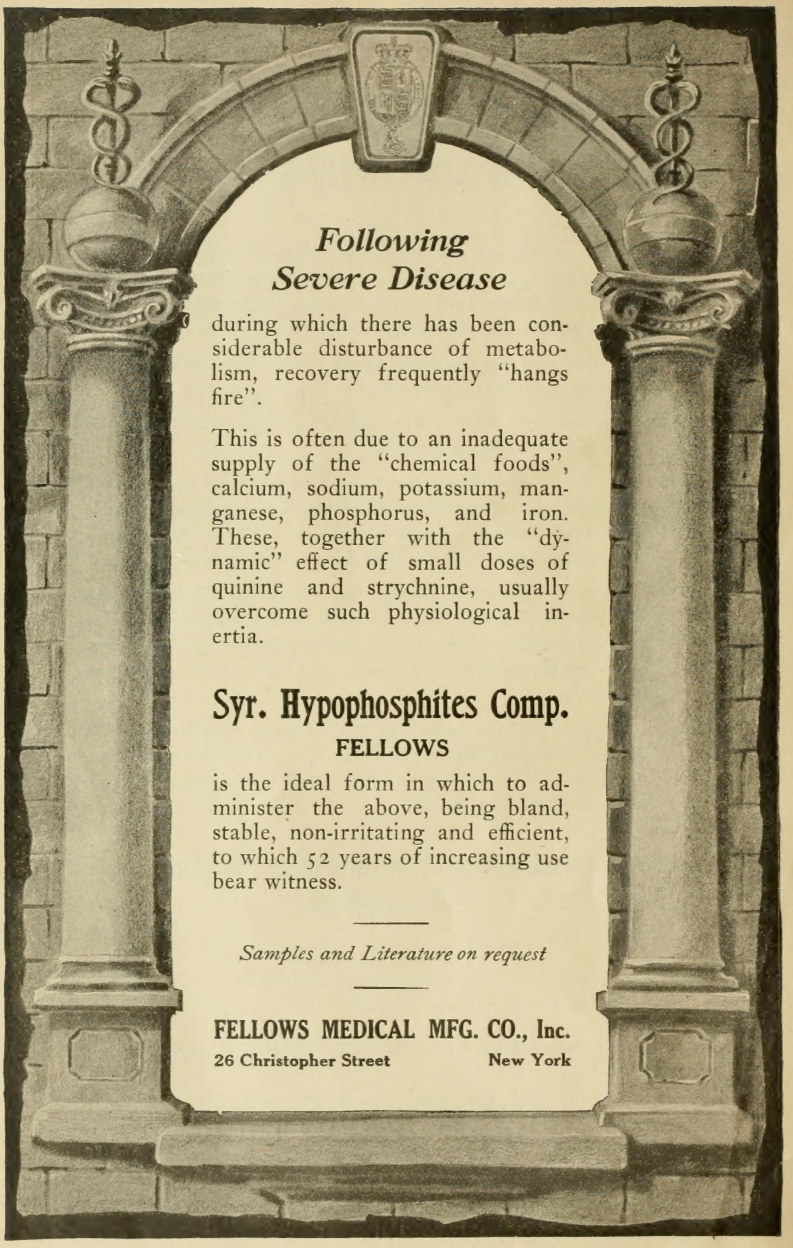
Influenza-Pneumonia Vaccine
(Prophylactic)

Bio. 632. Three bulbs (½ mil, 1 mil, 1½ mils), one prophylactic treatment.
Bio. 633. Three syringes (½ mil, 1 mil, 1½ mils).
Bio. 634. One 5-mil vial.
Bio. 635. One 20-mil vial.

We commend this vaccine to the consideration of physicians.

Parke, Davis & Company

DETROIT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THE BRANDOW PRINTING COMPANY, ALBANY, N. Y.

FOUNDED 1838

UNION UNIVERSITY

MEDICAL DEPARTMENT

Albany Medical College

Clinical Facilities: The hospital services are directly under control of the Medical College. There are teaching services both in Medicine and Surgery, and the students have immediate responsibility under supervision.

Laboratories: The laboratories, in charge of full-time teachers, provide ample facilities for undergraduate teaching, for graduate instruction, and for research.

Admission Requirements: Each candidate must furnish evidence of the satisfactory completion of at least two years' study, in a recognized college or scientific school, including courses in physics, chemistry (including organic), biology, English and a modern foreign language.

Women are admitted. Classes are restricted in number.

Tuition: The charge for tuition is $160.00 a year and $5.00 for matriculation. There are no extra fees except for rental of microscopes, laboratory breakage, and certain expensive supplies.

The academic year begins Sept. 22, 1919. All inquiries and other communications should be addressed to Thomas Ordway, M.D., Dean, Albany Medical College, Albany, N.Y.